

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004040

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 437 STATE FILE NUMBER

FILED JAN 22 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>4281 San Francisco Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>B.</u> Last <u>Robinson</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1898</u>	9. AGE (last birthday) <u>64</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clark Typist</u>
11. BIRTHPLACE (City and state or country) <u>Homer G. Phillips Hosp. Pittsburg, Kansas</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		

13a. FATHER'S NAME <u>Rev. Nelson Beasley</u>		13b. MOTHER'S MAIDEN NAME <u>Lula Askew</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Gwendolyn B. Robinson 4281 San Francisco</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>CHRONIC BRAIN SYNDROME</u> DUE TO (c) <u>4341</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>Undetermine</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>5:10</u> a.m. <u>p.m.</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <u>12/26/62</u> to <u>1/13/63</u> and last saw her alive on <u>1/13/63</u> Death occurred at <u>5:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>C.D. Vermillion M.D.</u> (Degree or title)		22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>1/13/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/17/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>

24. FUNERAL DIRECTOR <u>C.W. Roberts Und. Co 1416 N. Taylor Ave</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 15 1963</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>
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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59
1
2 210
3
4 3
5 3
6
7 1
8 1
9
10
11
12 52-6
13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Saylor

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.